Short title: Anaesthesia Standards BP

Introduction

ANZCA has developed a raft of professional documents[1] whose purpose is to drive improvements in standards of practice. They are invaluable documents providing evidence-based or, where this is lacking, consensus-based recommendations aimed at optimising patient care.

While earlier documents targeted accredited training facilities their value was recognised in broader general terms to be applicable across the spectrum of anaesthesia practice in both public and private facilities. Consequently, subsequent revisions and new documents are developed in this context.

Over time, these documents became regarded as “standards”, and while they contributed significantly to driving standards of practice, they were not of themselves standards. The benefits of identifying and articulating standards are numerous, especially the ability to compare performance against benchmarks.

The need for a set of standards has become increasingly evident as a result of queries from doctors, nurses, hospital administrators, and legal firms seeking opinions on standards of practice. Such queries revealed confusion as to how to interpret existing ANZCA professional documents, and whether failure to follow only a small portion of the recommendations contained in each guideline constitutes a breach in standard. Greater clarity was achieved by highlighting that these documents provide advice regarding optimisation of patient care. They do not set benchmarks of performance that can serve as standards. Consequently, standards need to be set to which guideline recommendations can be linked to facilitate meeting or exceeding the benchmarks.

The term *standard* has origins dating back to Egyptian and Babylonian times when it referred to “weight, measure, or instrument by which the accuracy of others is determined”, from which it came to be accepted as an authoritative or recognised exemplar of quality or correctness.

Quality improvement, on the other hand, relies on identifying evidence-based benchmarks against which performance can be compared.

Only through the evaluation of outcomes against criteria can performance be determined. Quality reflects whether intended outcomes have been achieved, while safety is a reflection of unintended adverse outcomes or harm.

A distinction needs to be made between ‘safety’ and ‘safe’. The term ‘safety’ is defined in terms of adverse outcomes in relation to risk; however, the term ‘safe’ is defined as absence of harm and is generally used to justify processes (techniques) without reference to risk. No medical treatment is absolutely safe as there is always the risk of unanticipated harm. The cornerstone to safety is minimisation of risk through risk management. It is for this reason that the accompanying standards are not designed to benchmark what is safe, but rather benchmark safety.

The Donabedian model[2] of quality considers structure, process, and outcomes. It is a useful tool than can help to identify indicators for developing standards, against which performance can be gauged. Without such standards there are no objective evidence-based criteria to evaluate whether expected levels of care are being met or even exceeded.

Quality of outcomes and performance can be considered on a broader level including improved patient outcomes (patient reported and/or clinician observed), improved patient experience, improved clinician experience, and lowering health costs.[1] Each of the standards provides a statement of quality. A prescriptive method to measure performance against the benchmark has not been provided, as context and resources will determine the most appropriate approach.

Governance and leadership are essential foundations that promote and co-ordinate training and ongoing education of anaesthetists, setting standards for safety and quality, supporting clinical and professional development including development and publication of guidelines and position statements, advocating for community and indigenous health, and driving advances within healthcare facilities. The Australian and New Zealand College of Anaesthetists (ANZCA) fulfills these roles.

ANZCA is the only Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) accredited college responsible for training and qualification of specialist anaesthetists in Australia and New Zealand. The quality of ANZCA's training program is recognised internationally. ANZCA is recognised as a leader in anaesthesia research.

ANZCA's core functions include training and education. Consistency of training and assessment processes is ensured through the ANZCA training programs, which set the minimum standard for Safety, and are reflected in Standard 1, below.

Ongoing education is an essential function that promotes continuous improvement in the performance of anaesthetists. Use of evidence-based benchmarks for the purpose of comparisons allows anaesthetist performance and outcomes to be made. A conduit for this is participation in the CPD Practice Evaluation (PE) activities and constitutes one of the factors that drives improvement. Standards 2 to 5 are intended as benchmarks for quality of performance.

Discussion

The varying formats used by standard-setting bodies was considered, with acknowledgement of the merits of each format. In the setting of clinical anaesthesia practice, which entails clinical care standards, the ACSQHC format is most appropriate. However, incorporating an explanation of the intention of the standard, as per the NSQHS Standards, serves to highlight the purpose of each standard.

Therefore, each standard specifies a statement of quality of performance that serves as the targeted benchmark. A set of criteria have been identified as indicators, which consist of actions to be undertaken that support attainment of the standard.

In developing the content of these standards, considerable thought was given to ensuring that the purpose of the document and its scope were clearly defined. The aim of setting standards was to align with and facilitate fostering safety and quality in patient care.

[1] Institute of Healthcare Improvement (IHI) Quadruple aim model available here.

The project group then agreed that the standards should represent the high-level overarching principles spanning the entire perioperative journey applicable both to anaesthetists and healthcare facilities given that outcomes are dependent on performance of systems as well as individuals.

Anaesthetists participate in a variety of ANZCA Roles (*link to ANZCA Roles*). It was agreed that the ANZCA standards do not need to be developed where there are already existing standards by regulatory authorities or other standard setting bodies. On that basis, the following have not been included:

- Scholar role
    - Teaching – standards set by AMC
    - Research – standards set by ethics committees
- Professionalism – standards set by MCNZ and MBA codes of conduct

Other standard setting organisations include NSQHS, ACQSHC, HQSC, Standards Australia and Standards New Zealand.

Therefore, the focus of the accompanying standards is on medical expert, communicator, collaborator, leadership and management, advocacy, and scholar (learning and CPD).

Standards

Standard 1: Patients are cared for in a professional, culturally sensitive, and ethical manner by registered qualified medical practitioners working within their defined scope of clinical practice.

The primary focus of standard 1 is the relationship between patients and anaesthetists. Confidence in the professionalism and skills developed by anaesthetists builds trust, which enhances bidirectional communication. Insights into the rigour of the training program supervised and administered by a bi-nationally accredited college that is internationally recognised as a leader in its field, promotes such confidence.

ANZCA is the only accredited[3] college for specialist anaesthesia training in Australia by the Australian Medical Council (AMC) and in New Zealand by the Medical Council of New Zealand (MCNZ). ANZCA is responsible for training and qualification of anaesthetists, setting standards, and for ongoing education through its continuing Professional Development (CPD) program. The college actively supports research. Its advocacy roles include fostering safety and quality, cultural safety, indigenous health, and wellbeing.

In addition to training specialist anaesthetists, a joint initiative between ANZCA, ACRRM, and RACGP has resulted in the development of a new two-year training program for rural GPs in Australia. Those GPs who satisfactorily complete the course will be awarded the Diploma of Rural Generalist Anaesthesia (DRGA). This qualification does not confer specialist anaesthetist status; however, it recognises the critical role that GPs with advanced training in anaesthesia play in many rural and remote communities.

Leadership is recognised as an essential skill for anaesthesia given that anaesthetists work within teams. In the operating suite environment, anaesthetists are required to scan and monitor the environment so as to be situationally aware of all factors that may impact on patient care. In the wider medical context of the healthcare community, the ability to work collaboratively within

multidisciplinary teams and advocate for patients is enhanced through facilitating such engagement and involvement. Anaesthetists are well positioned to effect this and are encouraged to do so.

Apart from the medical expert skills possessed by anaesthetists to manage the acutely deteriorating patient, including acute resuscitation and advanced airway management, other factors impacting on patient outcomes include considerations of communication, collaboration, patient advocacy and professionalism. Leadership skills may influence the outcomes in all of these circumstances, both for patients and for team members.

Cultural safety is core to any interaction with any individual. Indigenous issues are specifically pertinent to Australia, with regard to Aboriginal and Torres Straight Islanders and to New Zealand with its Māori people.

In addition, the multicultural communities that make up Australian and New Zealand populations requires anaesthetists to be aware of cultural concerns and be able to communicate with them at their level.

Of importance is the applicability of cultural issues both to patients as well as to staff and team members.

Research underpins training, education, and standards of clinical practice and consequently, its importance cannot be sufficiently stressed. An understanding and appreciation of research is essential for advancing clinical care, as evidenced by their contribution to quality assurance/quality improvement activities such as audits, as well as the ability to evaluate the outcomes of one's own clinical care. Therefore, participation in research is actively encouraged. In acknowledgement of the difficulty to engage in meaningful research without a public hospital appointment, it is expected that healthcare facilities support the ability to undertake research.

Standard 2: Patients being considered for surgery or procedures requiring anaesthesia, present in optimal condition, have sufficient understanding of the risks and benefits of anaesthesia and are enabled to participate in shared decision-making.

This standard sets the benchmark for pre-anaesthesia care. It has been separated from intraoperative and postoperative stages both because it is a critical component determining patient outcomes but also because it helps to dispel the perception that anaesthesia care purely pertains to intraoperative management. Furthermore, with the progress of ANZCA's perioperative specialist qualification, this standard is equally applicable in that setting.

This standard recognises the limitations that may arise in time-critical emergencies.

The pre-anaesthesia consultation consists of several components including assessment of patient health in the context of risks and consultation whereby risks are discussed as well as alternative management plans. Although they may occur on separate occasions, they are integral to pre-anaesthesia care.

Cultural awareness and sensitivity are crucial elements with regard to shared decision-making, informed consent and its documentation. This is especially pertinent for patient co-operation and participation in any prehabilitation and multidisciplinary consultations.

Any multidisciplinary team involvement needs to be timely as there are recent suggestions that this may unnecessarily delay surgery if not conducted in a timely manner.

The ideal time to commence pre-anaesthesia preparation will be determined by many factors, however, there are advantages in considering initiating the process close to the time any procedure is first contemplated. This is especially advantageous in providing time for patients and carers to consider and understand the risks associated with their proposed treatment and possible outcomes. It also offers sufficient opportunity for shared decision-making where any concerns raised can be discussed and subsequent decisions supported by both patient and clinician. Such interactions form the basis of informed consent.

Standard 3: Intraoperative management follows best-practice guidelines.

This standard refers specifically to intraoperative anaesthesia care. There are many facets to intraoperative anaesthesia management spanning several ANZCA roles including medical expert, professionalism, communication, collaboration, and leadership. All these roles impact on outcomes whether directly on patient care or indirectly through maximising effectiveness of the team contributing to patient care.

The term *best-practice* is the subject of much debate with opponents maintaining that best-practice does not necessarily reflect *good* practice. Nonetheless, for the purposes of this standard, it is accepted that best-practice is understood to reflect what is currently regarded as optimal. Guidelines are developed with this in mind and consequently, following nationally accepted guidelines constitutes the essence of this standard.

The criteria indicative of this standard being met recognise the contributions of teams as well as individuals and the interactions between them. Responsibilities of anaesthetists are captured within this standard, which differentiates between role substitution and task delegation.

Definitions:

- Role - position, responsibility, competencies
- Task – the raft of activities that need to be undertaken to fulfil a role

Anaesthesia is a medical role for which anaesthetists retain responsibility irrespective of any tasks that may be delegated to other staff.

Availability of equipment deemed essential for safe anaesthesia management as well as for monitoring, and availability of staff are additional indicators that support this standard.

Standard 4: Patient comfort and recovery are managed during the recovery period and patients are discharged with the necessary understanding of their discharge plan.

The quality of care provided during the pre-anaesthesia and intra-operative phases is reflected in the post-operative recovery. As a continuum of care the postoperative management of ongoing needs including patient comfort are integral to optimisation of outcomes. In recognition

of the importance of this component, Standard 4 articulates the benchmark applicable to postoperative care.

Within the intent of the standard, an essential element is to identify the responsibilities of anaesthetists in the management during the postoperative stage. It highlights the essential interactions requiring clear communication with colleagues to ensure that those involved in patient care remain informed and can contribute to developing any plan for post-operative management. The need to consider prescription of opioids in the context of opioid stewardship is also captured in this standard.

In addition to communication with colleagues, communication with patients/family/carer is essential to provide them with any specific instructions regarding postoperative and post-discharge plans, and to ensure that these are understood.

Standard 5: Healthcare facilities are managed in accordance with regulatory requirements including administrative processes, as well as staffing and equipment to support safety and quality in anaesthesia care.

Anaesthetists work in diverse settings, ranging from large tertiary and quaternary referral hospitals in major centres through to small regional and remote hospitals. In addition, there are stand-alone facilities including dental surgeries and office-based locations. Standard 5 is the benchmark applicable to all such healthcare facilities to ensure that they operate within local jurisdictional regulatory requirements as well as ensuring that anaesthesia care is commensurate with safety and quality for the services they provide.

Promoting awareness of the requirements that constitute safety and quality in anaesthesia care offers healthcare facilities the opportunity to collaborate with clinicians and ensure that such requirements are met. This includes ensuring that sufficient suitably trained staff are available as well as equipment deemed necessary for safe delivery and recovery from anaesthesia.

Healthcare facilities have a responsibility to ensure that anaesthetists appointed to their facility are suitably credentialled and have the experience applicable to their requested defined clinical scope of practice. The value of anaesthetists participating in these decisions is underscored in this standard.

Apart from the regulatory requirements for continuing professional development (CPD), the quality of service provided by anaesthetists in any healthcare facility is very much determined by their CPD. As such, it is in the interest of healthcare facilities to promote and support CPD activities, which is also linked to workplace wellbeing.

Summary

As an internationally recognised leader in anaesthesia, one of ANZCA's many roles is to promote standards of clinical and professional practice. The conduit for this has been the development of ANZCA's professional documents, which serve as an extremely valuable resource. However, there has been a void in the availability of a set of standards against which performance can be judged or compared, and to which the professional documents can be specifically referenced.

The development of the accompanying *Standards for anaesthesia* are intended to fill that void and allow meaningful evaluation of performance against a set of benchmarks applicable to the spectrum of anaesthesia practice.

References

1. ANZCA professional documents. Available from: https://www.anzca.edu.au/safety-advocacy/standards-of-practice/policies,-statements,-and-guidelines

2. Donabedian, A. (1988). "The quality of care: How can it be assessed?". JAMA. 260 (12): 1743–8.

3. Australian Medical Council (AMC) accredited colleges available at this link

Further reading

Dental Council of New Zealand. Sedation practice standard. 2016. Available from: https://www.dcnz.org.nz/assets/Uploads/Consultations/2016/Attachment-2-Sedation-practice-standard.pdf

Standards Australia. Standardisation guide 003: Standards and other publications. 2019. Available from: https://www.standards.org.au/getmedia/d9da035d-2fbc-4417-98c1-aa9e85ef625d/SG-003-Standards-and-Other-Publications.pdf.aspx

Australian Commission on Safety and Quality in Health Care (ACSQHC). Clinical Governance Standard User Guide. Available from: https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance/clinical-governance-standard

Faculty of Pain Medicine (FPM). PS11(PM) Procedures in pain medicine clinical care standard. 2020. Available from: https://www.anzca.edu.au/getattachment/accd6913-3027-4d3b-9297-12224425a46b/PS11(PM)-Procedures-in-Pain-Medicine-Clinical-Care-Standard

Professional documents of the Australian and New Zealand College of Anaesthetists (ANZCA) are intended to apply wherever anaesthesia is administered and perioperative medicine practised within Australia and New Zealand. It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of these ANZCA documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these ANZCA documents. Each document is prepared in the context of the entire body of the college's professional documents, and should be interpreted in this way.

ANZCA professional documents are reviewed from time to time, and it is the responsibility of each practitioner to ensure that he or she has obtained the current version which is available from the college website (www.anzca.edu.au). The professional documents have been prepared having regard to the information available at the time of their preparation, and practitioners should therefore take into account any information that may have been published or has become available subsequently.

Whilst ANZCA endeavours to ensure that its professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

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